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REGULAR FEATURES

Uchunguzi (Journal Watch/*Montre de Journal*)



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Uchunguzi means investigation in Swahili and provides a summary of some of the most recent international literature as presented in other leading journals, but with an emphasis on what is relevant to our continent.

The Good Samaritan

Most states in the USA have ‘Good Samaritan’ laws that oblige doctors to stop and render emergency treatment under certain circumstances, without incurring legal liability even if they are negligent. Whether doctors are legally obliged to stop and render assistance at road accidents in most countries across the world remains controversial. In 1978, the South African Medical and Dental Council ruled that ‘in cases of emergency a practitioner is obliged to render assistance in all circumstances’. It has therefore been said that ‘where persons are in a situation where their life or health will be seriously endangered unless they receive immediate medical treatment, a practitioner who is available may not ethically refuse to attend such patients unless there are compelling circumstances that prevent the doctor from acting’. The authors conclusion in this review provides a good guide that can be adopted by practitioners in countries with no ‘Good Samaritan’ laws. Generally, doctors who are the first to come across injured people at a road accident should stop and render assistance unless they may be exposed to personal danger or injury if they stop, are mentally or physically incapable of rendering assistance, or other medical or paramedical practitioners are already present. Where there is the threat of personal danger to the doctors they must immediately report the accident to the police and advise them to send protection and call for urgent ambulance assistance. They should remain near the scene until the police and ambulance arrive and check that paramedics are available to stabilise the injured before departing. Where there is the threat of danger, doctors are mentally or physically unable to assist or other medical or paramedical practitioners are at the scene, doctors may or may not be required to stop – depending on the circumstances.

McQuoid-Mason DJ. When are doctors legally obliged to stop and render assistance to injured persons at road accidents? *S Afr Med J* 2016;106(6):575–7.

Emergency care. . . what do Zambians want?

In February 2013, a road traffic accident on the Zambian Great East Road killed 58 people, prompting the Zambian Ministry of Health to create an action plan to improve emergency response. In line with this, the objective of this study was to identify critical interventions necessary to improve the Zambian emergency care system by determining the current pattern of emergency care delivery as experienced by members of the community, identifying the barriers faced when trying to access emergency care and gathering community-generated solutions to improve emergency care in their setting. Twenty-one community focus groups with 183 total participants were conducted in three Zambian provinces, split equally between the provinces and an additional six focus groups were conducted with Zambian healthcare providers. Analysis of the focus group data identified several common themes. Community members experience a wide range of medical emergencies, and they rely on family members, neighbours and Good Samaritans for assistance. These community members frequently provide assistance with transportation to medical facilities and attempt some basic first aid. Barriers to emergency care identified related to the multiple components of an emergency care system: transportation, healthcare provider deficiencies, lack of community knowledge, the national referral system and police protocols. Community- and provider-suggested recommendations included; creation of community training courses in emergency awareness and first response, strengthening the formal prehospital care system by creating a national emergency phone number, increasing emergency transportation options and training ambulance staff and police officers to provide prehospital care and creation of a dedicated national emergency care system, where all healthcare facilities

follow triage protocols, have providers trained in emergency care, and include dedicated areas specifically for emergency resuscitation and stabilisation. The need to integrate emergency care into healthcare systems is receiving increased attention as it has been estimated that emergency care systems could address 45% of deaths and 36% of disability in low-income and middle-income countries.

Broccoli MC, Cunningham C, Twomey M, Wallis LA. Community-based perceptions of emergency care in Zambian communities lacking formalised emergency medicine systems. *Emerg Med J* 2016. <http://dx.doi.org/10.1136/emmermed-2015-205054> [Epub ahead of print].

Paediatric trauma care in low and middle income countries

Traumatic injuries are a significant cause of death and disability worldwide causing over five million deaths annually including 830,000 children. Ninety-five percent of these deaths (both intentional and unintentional) occur in LMICs. The death rate in LMICs is almost twice that in high-income countries (HICs) and the rate for DALYs in LMICs is more than three times that in HICs. The WHO estimates up to half of all children who present to a hospital with unintentional injuries will be left with a lifelong disability. The top five aetiologies for unintentional injuries reported by the WHO are road traffic injuries (RTI), falls, burns, drowning, and poisoning. This review details the evaluation and management of traumatic injuries in paediatric patients and provides a good summary of evidenced-based adaptations for trauma management by systems in limited- and extremely limited resource settings. The authors also recommend attention to protocolised care, regionalisation of care, development of centres of excellence within each LMIC, and an emphasis on injury prevention. Given limitations in the availability of the resources necessary to provide the levels of care found in high-income countries, strategies to prevent trauma and make the best use of available resources when prevention fails, and thus achieve the best possible outcomes for injured and critically ill children are vital.

Kiragu A, Dunlop S, Wachira B, Saruni S, et al. Pediatric trauma care in low- and middle-income countries: A brief review of the current state and recommendations for management and a way forward. *J Pediatr Intensive Care* 2016. <http://dx.doi.org/10.1055/s-0036-1584676> [Epub ahead of print].

How bad is the problem?

Emergency conditions are thought to make up a large part of the global burden of disease, and high-quality emergency care has the potential to address and prevent a substantial portion of death and disability around the world. In this review, the authors estimate the global and national burden of emergency conditions, and compare them to emergency care usage rates. From 291 Global Burden of Disease 2010 conditions, 90% of deaths and 84% of disability-adjusted life years (DALYs) around the world were due to emergency conditions, driven in nearly equal part by conditions that must be addressed within hours to days of onset and conditions with common acute decompensations. Of the DALYs attributable to emergency conditions globally, 59% was caused by non-communicable diseases (NCDs), with communicable diseases (CDs) and trauma representing 28% and 13%. The proportion of emer-

gency condition deaths and DALYs from NCDs and CDs were nearly equal in low-income countries (LICs), whereas in high-income countries (HICs), NCDs made up 83% of deaths and 80% of DALYs, with CDs representing only 7% and 6% of deaths and DALYs from emergency conditions. Emergency facilities in low-income and middle-income countries (LMICs) serve large patient populations with high levels of critical illnesses and mortality in populations with higher burden of emergency conditions, yet the current rates of emergency usage are exceedingly low when compared with those of HICs. These observations were true whether deaths or DALYs were used to measure burden, and whether conditions commonly associated with acute decompensations were included in the calculations. Emergency medicine has the potential to play an integral and vital role in global health. Prioritising and broadening access to high-quality emergency care in LMICs and dedicating more resources to strengthening emergency care research could have a powerful impact on the Global Burden of Disease.

Chang CY, Abujaber S, Reynolds TA, et al. Burden of emergency conditions and emergency care usage: new estimates from 40 countries. *Emerg Med J* 2016. <http://dx.doi.org/10.1136/emmermed-2016-205709> [Epub ahead of print].

Ferrying the injured in Lusaka

In 2013, 973 million people suffered injuries requiring health services and 4.8 million died from injuries. Survival from severe injuries is linked to rapid initiation of treatment. Achieving this goal requires a system of prehospital transport—formal or informal—to assist those who could not otherwise reach care due to physical or resource limitations. This essential component of effective emergency care is lacking especially in Africa despite data that show the majority of trauma fatalities in Africa occur before an injured patient ever receives care. From September 2011 to February 2012 a prospective, observational study was conducted to capture data on trauma patients presenting to University Teaching Hospital (UTH) in Lusaka, Zambia—a 1400-bed urban, tertiary hospital that is the primary referral hospital for 1.5 million people in Lusaka and the academic referral hospital for the country. Of the 3425 patients arriving alive to the hospital, data on transport method and transit time was available for 3264 individuals (95.3%). The majority of trauma patients arrived via private car (1743, 53.4%) or public transport (1231, 37.7%) and only a small number of patients arrived via any form of ambulance (194, 5.9%). Despite being a regional and national referral hospital, 66% of patients arrived within 6 h of the original injury and about a quarter of patients (23%) arrived within 1 h of injury, 95.0% of them using private or public transport. Recent studies in LMICs have cited the effective use of diverse prehospital transport methods including private vehicles, public transport, commercial transport, police transport, non-motorised transport, as well as formal Emergency Medical Services (EMS). Since a higher proportion of patients in LMICs with salvageable injuries die outside the hospital than in high-income countries, emphasis must be made on prioritising rapid transport of sick and injured patients to health facilities using an integrated, multipronged approach that incorporates community members, health professionals, and coordinates existing public transport services.

Mowafi H, Oranmore-Brown R, Hopkins KL, et al. Analysis of prehospital transport use for trauma patients in Lusaka, Zambia. *World J Surg* 2016. <http://dx.doi.org/10.1007/s00268-016-3629-4> [Epub ahead of print].

Emergency care...the family experience

The emergency centre (EC) setting is fast paced and unpredictable in nature. The emotional turmoil which is thrust upon a family in the event of sudden traumatic injury or illness to a loved one can be debilitating and families are dependent on the health professionals in the EC not only to give acute care to their loved one but also to walk them through the process of dealing with the current crisis. In a recent quantitative, descriptive study conducted in a level 1 trauma care facility in a public tertiary academic hospital in Johannesburg, South Africa, the authors sought to determine the needs of family members accompanying patients into the EC, and if these needs were met. Fifty participants were approached upon entering the EC before they experienced the services rendered by the EC staff to determine what families ranked as being their most important needs and a second group of 50 different partici-

pants accompanying different patients was approached upon leaving the EC to determine their level of satisfaction with the services for meeting their needs. The top five ranking needs of family members accompanying patients into the EC were; to be assured that the best care possible has been given to your relative, to feel hospital staff care about your relative, to have questions about the condition of your relative answered honestly, to talk to a nurse and to have explanations given in understandable terms. The top five ranked needs that families leaving the EC thought were met were; to feel like there is hope, to have toilet facilities nearby, to feel hospital staff care about your relative, to be assured that the best care possible has been given to your relative and to be assured of the comfort of your relative. The findings of this study have important implications for the clinical practice of the emergency nurse. Families in the EC have a clear need for support and communication and the emergency nurse may offer more holistic nursing practice, taking into consideration the family in crisis.

Botes ML, Langley G. The needs of families accompanying injured patients into the emergency department in a tertiary hospital in Gauteng. *Curationis* 2016;39(1):1567.